Technical Assistance Document 3

THE CHILD AND FAMILY TEAM PROCESS

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

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Purpose

To define and describe the steps of the Child and Family Team process, and ADHS expectations for application of this approach with every enrolled child. This information is intended to operationalize *The Child and Family Team Practice Improvement Protocol* and to support (but not substitute for) specific teaching/coaching on the Child and Family Team process.

Targeted Population(s)

All TXIX and TXXI eligible members under the age of 21 receiving behavioral health services through the T/RBHA system.

Definitions

Child and Family Team (CFT) - a group of people that includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities, etc. In the case of children who may be legally dependent or delinquent, the custodial agency participates in the selection of team membership with the child and family. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan; and can therefore expand and contract as necessary to be successful on behalf of the child.

Child and Family Team (CFT) Facilitator – a person who ensures that the 12 Arizona Principles and the steps of the Child and Family Team process are delivered in a timely and effective way for the child and family, with high fidelity to and appropriate individualization of this process. A behavioral health representative – most often the Clinical Liaison -- will usually assume the role of CFT facilitator, but any member of the Child and Family Team can potentially do so.

Procedures - Steps in the CFT Process:

Nine essential steps make up the CFT process:

1. Engagement of the Child and Family
2. Immediate Crisis Stabilization
3. Strengths, Needs and Culture Discovery
4. CFT Formation
5. Behavioral Health Service Plan - Development
6. Behavioral Health Service Plan - Implementation
7. Ongoing Crisis and Safety Planning
8. Tracking and Adapting
9. Transition

The steps of the CFT process are not strictly linear, and are managed by the CFT facilitator based on the immediate needs and preferences of the child and family. (Examples of billing/encounter codes supporting each step in this process are included at the end of this document as Attachment 1.)

Step 1: Engagement of the Child and Family

"Engagement" is the active development of establishing trust in the helping relationship based on personal attributes including empathy, respect, genuineness and warmth.[1] The success of the CFT process depends on a foundation of trust that is built on effective engagement. The CFT process is a partnership, and engagement is the beginning of that partnership.

When and how should engagement of the child and family begin?

Engagement begins during the very first contact between the person/family and the behavioral health system. The behavioral health representative who first communicates with the child/family or other referral source is welcoming, engaging, non-judgmental, and responsive (including attentive to any immediate needs). From the beginning, all behavioral health representatives interact with the child/family or other referral source with respect and compassion, taking responsibility to understand any accommodations (e.g. in scheduling, location of appointments, child care or transportation needs) that may be required to support their engagement. This stance is maintained through any intake, early assessment, crisis stabilization and next steps/interim service plan activities that may precede formation of the CFT.

Engagement is evident during the Clinical Liaison's very first communication with the child and family. Whether in person or by telephone, that initial communication usually includes a short, clear explanation of the CFT process, avoiding the use of professional/system jargon. The Clinical Liaison sets a meeting with the child and family for a time and at a place of convenience for them, encourages the participation of additional family members and close family friends, and determines if additional assistance (e.g. family support services) are required to support their engagement in the process. There is no firm rule about the length of engagement conversation.

The first meeting continues the engagement process. The Clinical Liaison strives to get to know the child and family better and promotes the development of trust through *conversation* -- not a structured interview. The Clinical Liaison encourages the family to share its story through compassionate listening. The Clinical Liaison explores the primary family needs, long-term vision, and potential short-term goals that might become part of the developing service plan. While primary needs may require quick action (see Step 2), the Clinical Liaison should not move prematurely toward solutions.

Activities and behaviors that promote engagement should be evident throughout all subsequent work with the child, family and CFT.

Step 2: Immediate Crisis Stabilization

Crisis stabilization describes actions that address concerns about immediate safety, security and well- being such as those relate to medical needs, severe psychiatric symptoms, homelessness, behaviors of a child that might place others in jeopardy, or ongoing domestic violence. Any child entering foster care because of abuse or neglect is considered to be in crisis, due not only to the abuse or neglect, but also to the trauma of removal from one's family, and the needs of the child and the child's new caregivers to adapt to their new situation together. In addition to the immediate relief of existing concerns, crisis stabilization attempts to predict potential areas of crisis that may require preventive measures, stabilization, and clearly identified steps to respond should a future crisis occur.

[1] *Vroon VanDenBerg LLP, The Basics of the Child & Family Team Practice Model, Arizona 2003*

When and how should immediate crisis stabilization be accomplished?

For a child or family in great distress or immediate peril, crisis stabilization takes precedence over all other assessment considerations. Safety issues and crisis situations often include concerns about the child being in a potentially unsafe environment (child protection), or about the child potentially placing others in jeopardy (community safety). Other child serving systems (e.g. child welfare, juvenile probation) that may already be involved, may already have developed a safety plan, or may have initiated the child's referral to the behavioral health system, and are expected to be invited to help shape crisis stabilization and safety plans. The initial assessment helps the Clinical Liaison to identify safety issues, crisis situations and any needs for particular assistance (e.g. family support) by formulating the Next Steps/Interim Service Plan. The crisis stabilization plan includes specific objectives and strategies to support the design and timely availability of all necessary supports and interventions. When assistance may be needed to stabilize a crisis, it is the Clinical Liaison's responsibility to secure it.

Step 3: Strengths, Needs and Culture Discovery

The Strengths, Needs and Culture Discovery is the transition from immediate crisis stabilization to information gathering that will support service planning and delivery. It provides essential information from which to build strength-based, customized individual service plans that respect the unique cultures of children and their families. It is arguably the most important step in the CFT process. It allows the CFT to develop options, and ultimately a highly individualized plan that is likely to "fit" with *this* child and family in a way that attracts their commitment to and investment in its success.

By identifying strengths, assets and sources of support, the Strengths, Needs and Culture Discovery expands the array and volume of resources available to the team beyond formal, categorical services.

What are the specific purposes of the Strengths, Needs and Culture Discovery?

There are three overall goals of the Strengths, Needs and Culture Discovery:

1. Identify strengths, assets, and resources that may be mobilized to meet family needs for support.

2. Learn about and understand the culture of the family so the eventual CFT plan "looks like" and "feels like" the family (i.e. is culturally sensitive, and therefore likely to be a plan the child and family will support and participate in).

3. Record the child and family vision of a desired future, and any needs that must to be initially satisfied to begin achieving this desired future. A clear vision provides the context for what the child and family will work to achieve. Needs are immediate areas of focus, usually identified by the child and family.

Needs should not be framed in terms of formal services. Needs are sometimes primary (e.g. medical attention, shelter), but usually identification of needs will stem from the behaviors seen by the family or team as problematic, and from exploring the reason for/function of such behaviors.

Although the Strengths, Needs and Culture Discovery should examine all of the family's major life domains (e.g. family, social, residential, behavioral/emotional/psychological, spiritual, cultural, educational/vocational, safety, legal, health, financial, recreational), needs are not expected to be identified in every domain explored. People and families tend to identify needs they are experiencing in only one or two domains at a time. Once initial needs are addressed (and/or new strengths and resources identified), then additional needs are likely to be identified.

A thorough Strengths, Needs and Culture Discovery allows the service plan to include strength-based options that reflect the culture of the family. Rather than focusing exclusively on "fixing" the child's problems (an approach which has likely already failed) this process allows the CFT to identify the unique skills, talents, interests and resources that the child and family can engage and enhance to overcome and compensate for the deficits that may exist. This will better allow the child and family to create more meaningful and longer lasting change than would a deficit-based approach.

When and how should one facilitate the Strengths, Needs and Culture Discovery process?

The Strengths, Needs and Culture Discovery begins with an interview. Although the length may vary, the interview generally takes between one and two hours. It may occur over several sessions. The interview is conducted in a safe and comfortable place, and at a convenient time, as chosen by/with the family. Individuals who know the child and family well enough to substantially contribute should be invited to participate in the Strengths, Needs and Culture Discovery interview.

The findings of the Strengths, Needs and Culture Discovery interview are recorded in narrative format. (The Family/Community Involvement Addendum may seem similar to, but does not alone complete, the Strengths, Needs and Culture Discovery interview.) The Clinical Liaison provides the written discovery to the family and other participants for review in a follow-up meeting. Additional strengths often occur to the family after the interview that they would like to add to the discovery. Such additions can be made to the Strengths, Needs and Culture Discovery at any time. Families are asked to check the document for accuracy. It is recommended that the written discovery document be completed within three business days of completion of the interview, as the richness of the interview may be lost if extended longer.

What is the relationship between the behavioral health assessment and the Strengths, Needs and Culture Discovery?

When a child enrolls in the behavioral health system, the initial assessment (refer to ADHS or T/RBHA specific version of Provider Manual Section 3.9) is completed within 45 days of the child's referral to the behavioral health system. The "core" assessment, usually completed at the initial ("intake") appointment, is intended to identify the immediate needs and strengths of the child/family, and provides a foundation for ongoing assessment. The core assessment is intended to support the development of the CFT itself, and to produce enough information to decide what, when and how initial care ("Next Steps/ Interim Service Plan") should be delivered.

The core assessment and any addenda completed at the initial/intake appointment should serve as building blocks for the Strengths, Needs and Culture Discovery process the Clinical Liaison then carries forward. The complete initial assessment comprises the "core," the Strengths, Needs and Culture Discovery; and any addenda relevant to the child and family.

Strengths, Needs and Culture Discovery is both an event and an ongoing process. As an event, it calls for a planned meeting and interview process with the child, family, and others who know well and care about the family. As an ongoing process, it expects that the CFT will be facilitated to continue to discover family strengths and important aspects of family culture for as long as it supports the child and family. New strengths will frequently emerge as earlier plans are successfully implemented, and should update the narrative document. The narrative document should also serve as a basis for the clinical formulation developed in the initial assessment.

The Strengths, Needs and Culture Discovery process ultimately weaves all information developed in the core assessment and addenda, and sometimes from other documents/collateral information[2], together with the family's story, and input from members of the team that forms around the child and family.

Due to its importance, a Strengths, Needs and Culture Discovery should be completed for each enrolled child as part of the initial assessment. The Strengths, Needs and Culture Discovery process must therefore be completed within 45 days of the initial/intake appointment.

Step 4: CFT Formation

The size, scope and intensity of involvement of the team members are driven by the objectives established for the child, reflecting those individuals needed to develop and coordinate an effective service plan. A CFT *may* consist of as few members as the child, a parent and a behavioral health representative. Ideally, it consists of between four and eight members, but expands and contracts as necessary to succeed on behalf of the child and family. Thus, some members of the team may be added or subtracted as the needs and strengths of the child and family change over time.

When and how should one facilitate formation of the CFT?

Building upon information developed during the initial core assessment, the Strengths, Needs and Culture Discovery results in the identification of individuals who care about, know well, and provide support to the child and family, who reflect their values and culture, and who are willing and able to participate. Friends, extended family, neighbors, members of the family's faith community, teachers, social workers, therapists and co-workers might be among those invited to join.

Experience has shown that a team comprised primarily by professionals tends to discourage family voice and choice, and results in a plan that relies solely on existing, formal services, and which fails to closely reflect the individual needs of the child and family. The Clinical Liaison should therefore establish as a goal the recruitment of more natural supports over time. When a child or family appears isolated (e.g. a single parent, a child in foster care), the Clinical Liaison may use genograms or other tools and techniques to help expand the number of team members or potential natural supports. The Clinical Liaison may also identify family support, peer support or other "system" resources that can help the child/family members to exercise effective voice in the CFT process.

In all cases, the Clinical Liaison should contact potential team members identified by the family (or guardian), to explain the CFT process, and the specific reasons they are needed on the team. The Clinical Liaison in attracting identified individuals to join the team will apply many of the same practices and skills described in Step 1: Engagement. Information about the date/time and location of the next team meeting should be shared. Sometimes team members may not need to, or may be unable to, attend every team meeting. In such instances, the Clinical Liaison should discuss the team's meeting agenda with the absent member in advance, and obtain information to be shared at the meeting on the member's behalf. The Clinical Liaison would subsequently call that member after the meeting to advise them of any decisions, outcomes and/or assignments.

Once the CFT is formed, its members will decide who will perform necessary roles over time. The Clinical Liaison may or may not continue to serve as the CFT facilitator.[3]

[2] Typically the Clinical Liaison reviews any previous assessments and evaluations, bringing pertinent information to the CFT to consider.

[3] The remainder of this document will refer to the "CFT facilitator," recognizing that the team may choose any member – including but not necessarily the Clinical Liaison – to fulfill the responsibilities of the CFT facilitator.

It is clearly expected that the CFT process will shift reliance over time from formally to informally facilitated support. That shift should be promoted and encouraged from early in the CFT process. The CFT facilitator should therefore model the skills needed to facilitate this process, so that team members may become aware of those skills and have opportunities to practice them as the team works together.

Step 5: Behavioral Health Service Plan – Development

A Behavioral Health Service Plan describes the needs, long-range vision and short-term objectives for the child and family, and the services that will best fit their needs. The plan must reflect the family's prioritization of needs, goals and significant cultural considerations; should incorporate pertinent, identified strengths within its strategies; should include clear assignments of team member responsibilities, with timeframes; and should include measures or other means by which the child/family and CFT can monitor accomplishments and progress. In the event that a family member (e.g. a parent) is receiving behavioral health services, the Behavioral Health Service Plan should also include the family member's plan, including involvement and information from the family member's clinical team whenever appropriate. The Behavioral Health Service Plan should serve as a single, unified guide for the child and family, even in cases where the child/family is involved with multiple child-serving systems at once.

The Behavioral Health Service Plan begins with the family's long-term vision of their desired future, and describes a realistic course of action, written so the child and family can understand the short term steps that will help them move forward, building and sustaining a realistic sense of hope. The Behavioral Health Service Plan should set objectives that can be readily accomplished and celebrated within a short timeframe. The intent of this approach is to encourage involvement, achievement and success, continually building on the strengths of the child and his/her family.

The initial Behavioral Health Service Plan should always be completed within 90 days of the child's initial referral to the behavioral health system.

When and how should one facilitate the development of the Behavioral Health Service Plan?

Once the CFT is formed, the team begins to work together to develop a Behavioral Health Service Plan. The first element of plan development is assisting the child and family to identify their needs, and their long-range vision of a desired future. "Long-range vision" might be imagined as the completion to the sentence, "Life would be better (in this domain) if…"

Once the family's prioritized areas are identified, the CFT facilitator then guides the planning process to long-range vision clarification, and short-term goal/objective setting. Long-range vision and short-term objectives can be identified or modified at any point during the CFT process. The modification of long-range vision and short-term objectives should be an ongoing process.

When needs, long-range vision and short-term objectives have been established, the next task of the CFT is to brainstorm strengths-based *options* to achieve the short-term objectives. The CFT facilitator shares the written Strengths, Needs and Culture Discovery narrative with the team members. This not only provides resources with which the team members can work to build realistic and effective strategies – it also can counterbalance any predominantly deficit-based perspectives a team member may have about the child/family, and it further incorporates strengths-based work into the "culture of the team" itself.

What is the essential content of the Behavioral Health Service Plan?

The Behavioral Health Service Plan describes the vision/goals, needs and objectives, and quantifiable measures and interventions, and is stated in the family's language. It is used by the behavioral health system as the format for documenting the plan's required elements. Some of the required elements of the Behavioral Health Service Plan exist to help make the plan more "concrete" – that is, practical and measurable (see Step 8: Tracking and Adapting). In specific cases, the CFT might add other documents to the Behavioral Health Service Plan format (e.g. a daily routine schedule, a specific strategy to address a particular behavior, terms and conditions of probation), to the extent the team feels it helps the child/family or other team members understand, embrace and carry out the plan as intended. All required elements are described in the *ADHS/DBHS Instruction Guide for the Assessment, Service Plan and Annual Update*.

ADHS intends that assessment and service planning be ongoing processes, resulting in plans that are continually changed to meet the changing needs of the child and family. Although technically the Behavioral Health Service Plan in Arizona is good for a maximum of one year, the CFT sets objectives that can be accomplished and celebrated in a much shorter timeframe, and that continually builds on the strengths of the child and family. The initial Behavioral Health Service Plan must be completed within 90 days of the person's initial appointment.

What are the CFT facilitator's essential responsibilities in supporting development of the Behavioral Health Service Plan?

The CFT facilitator bears primarily responsibility for building and sustaining an effective team culture. The CFT facilitator builds on earlier engagement and team formation experiences, and may further help shape the team by inviting its members to propose, discuss and accept ground rules for their work together. The CFT facilitator's own handling of logistics, details and team member interactions all present opportunities to enhance the effectiveness of the CFT. The CFT facilitator's essential skills can be divided into three areas:

1. CFT Meeting Preparation. The CFT facilitator informs the child and family of their rights, of the CFT facilitator's duty to report abuse and/or neglect of minors,[4] and obtains all necessary consents and releases of information prior to the team meeting. The CFT facilitator provides all information and guidance necessary for the development of a service plan. CFTs must be flexible, and when necessary adapt to accommodate parallel processes like Family Group Decision Making or permanency planning meetings (DES-ACYF), Person Centered Planning meetings (DES-DDD) and Individualized Education Plan meetings (special education). Likewise, it would be important to coordinate existing service plans for any other family members through a unified service planning process.

   With input from the child, family and others, and after the family has reviewed the information for accuracy, the CFT facilitator prepares the Strengths, Needs and Culture Discovery document for distribution and discussion at the team meeting. The CFT facilitator identifies the priority concerns of each team member, works proactively to minimize areas of potential conflict, and identifies mandates or "bottom lines" of any other involved child-serving systems. With input from the child and family, the CFT facilitator develops an agenda for the team meeting, schedules the meeting at a place and time that is comfortable for the family and

[4] Any person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means shall immediately report or cause reports to be made of this information to a peace officer or to the Department of Economic Security/Child Protective Services (DES/CPS). For further information, consult A.R.S. § 13-3620.

team members. The CFT facilitator attends to family members' needs (e.g. transportation, child care) to enable their full and active participation in the team meeting. The CFT facilitator invites all team members to the meeting. Team members who cannot attend are contacted in advance to elicit their input, as the team should make no decision without essential input from team members who may not be present. The CFT facilitator prepares any visual aids or tools to facilitate the meeting process. After the CFT meeting, team members who were unable to attend are contacted and informed of the meeting's results.

2. CFT Meeting Facilitation. The CFT facilitator helps the team to review and clarify the child and family's long-range vision, and uses it to guide the team in developing appropriate short-term objectives. The CFT facilitator manages the meeting effectively and efficiently, so that planned agenda items are completed during the meeting. During the meeting, options to achieve short-term objectives are developed and reviewed for effectiveness, for "fit" with the child and family, and with awareness of available resources and service capacity. Selected options are concrete, with clearly defined timelines for completion, and assigned responsibilities among team members for implementation. After the initial plan is developed, in subsequent team meetings the CFT facilitator leads a celebration of successes and accomplishments, reviews the status and outcomes of the written plan since the previous team meeting, guides the team in addressing any crises since the previous team meeting, guides the team in identifying any challenges or barriers, and in undertaking barrier resolution planning that is required.

   In all CFT meetings and activities, the CFT facilitator guides the team towards consensus. This task may be challenging at times. An effective CFT facilitator uses and promotes consensus-building techniques (e.g. compromise, reframing, clarification of intent, frequent refocus on the best interest of the child, and stepping back from "positions" to underlying principles) to meet such challenges.

   CFT Documentation. The CFT facilitator documents the plan, using the words of the child/family, using the Behavioral Health Service Plan format to denote required elements, and attaching any additional items to the Behavioral Health Service Plan as a single, cohesive and complete document. The plan defines the long-range vision of the family, identified needs, corresponding strengths, short-term objectives and selected options that reflect the culture of the child/family. The Plan is appropriately updated at each subsequent team meeting. Additions to the Strengths, Culture and Needs Discovery at subsequent team meetings are documented in progress notes so that the CFT can always work from an up-to-date narrative of strengths, resources, cultural considerations, and identified needs. Other important documentation (e.g. CFT meeting notes) can also be recorded in progress notes.

   The written plan assigns responsibility to team members or each task, contains timelines for implementation, and includes indicators or measures of effectiveness. The CFT facilitator enables team members to leave the meeting with any assignments and timeframes written down. The CFT facilitator informs team members unable to attend the meeting of decisions, outcomes and/or assignments. The CFT facilitator should furnish team members with an up-to-date copy of the Behavioral Health Service Plan within seven (7) days after the most recent CFT meeting.

Step 6: The Behavioral Health Service Plan - Implementation

Once the Behavioral Health Service Plan is established, those team members with specific assignments carry out their assigned responsibilities within the agreed timeframes. It is helpful for the CFT facilitator to arrange for team members to leave planning meetings with any assignments and

timeframes already written down. The CFT facilitator furnishes team members with an up-to-date copy of the Behavioral Health Service Plan within 7 days after the most recent CFT meeting.

Based on the recommendations and decisions of the CFT regarding the type, intensity and frequency of supports and services needed, the behavioral health representative formally secures any and all covered behavioral health services that will address the needs of the child and family. (A list of exceptions is included in *The Child and Family Team Practice Improvement Protocol*.) Any team members may accept assignments to secure other services and supports, sometimes from other involved public systems, often from community and other informal sources.

Some assignments may take the form of activities, or even of ways of interacting with a child. Designated team members also carry out these types of assignments. A Behavioral Health Service Plan may, for example, include a specific strategy that individuals interacting with the child will use to reinforce a particular behavior the child is learning. A plan may also include as a strategy that the child's Uncle will take him bowling each Friday evening.

Team members carry out assignments with diligence, and contact the CFT facilitator in a timely manner when an assignment appears unable to be completed. The CFT facilitator may draw from the CFT members, from supervisory or other resources as necessary, to help Plan assignments to be completed. There may be instances when a particular activity, support or service cannot be timely secured, even with such assistance. In those cases, the CFT facilitator elevates the "barrier" within the T/RBHA's Barriers Identification and Resolution process. Alternative or interim strategies, or other appropriate decisions, are made by the CFT to address identified needs in such circumstances.

Step 7: Ongoing Crisis and Safety Planning

Every Behavioral Health Service Plan includes a Crisis Plan component. The Crisis Plan addresses the question, "What might go wrong that might divert the CFT from successfully implementing the Behavioral Health Service Plan?" Proactive planning avoids poor decisions being made "in the heat of the moment," and instead capitalizes on the best creative thinking of the CFT members.

When and how should one facilitate the development of Crisis and Safety Plans?

After the initial Behavioral Health Service Plan is developed, the CFT facilitator next leads the CFT through a crisis planning process. Typically, a CFT meeting will be held to develop the Crisis Plan within a few days after the initial Behavioral Health Service Plan is developed. (The CFT facilitator understands that the steps of the CFT process are not strictly linear, and should be managed based on the immediate needs of the child and family.)

Crisis planning is often conducted with the child and immediate family, though other members may participate based on the family's preference, and the availability and expertise of those other members. Remember, other child serving systems (e.g. child welfare, juvenile probation) may already be involved, and may even already have developed a safety plan. Representatives from other involved child-serving systems are invited to help shape crisis stabilization and safety plans.

When Crisis Plans are developed by a subset of the CFT, the Crisis Plan is shared with the full team in an appropriately timely manner.

Crisis Planning follows a four-step model:

1. Prediction: At this point in the CFT process, the team responds to the question, "What is the worst thing likely to go wrong?"

2. Functional Assessment: The CFT facilitator guides the CFT in deconstructing the predicted crisis to gain an understanding of the unique elements and characteristics of the crisis process. What events, behaviors or behavior sequences are associated with the initial, middle and ending phases of the crisis?
3. Prevention: Based on learning during the functional assessment, what options, drawn primarily from the child/family strengths and community supports, can help to prevent those events, behaviors or patterns of behavior associated with the crisis process? Prevention strategies are described in the ensuing Crisis Plan.
4. Crisis Planning: The CFT facilitator leads the CFT in developing steps for managing the crisis in the event it occurs despite the prevention strategies. Crisis Plan steps specifically describe who will do what, when, and where. Crisis Plans often include specific names and phone numbers, as well as contingencies.

Safety Planning is similar to Crisis Planning. Safety Plans address ongoing conditions that pose significant risk to the child, family members or the community. Such high-risk conditions are not present with most children and families. While every Behavioral Health Service Plan includes a Crisis Plan component, Safety Plans are required only when high-risk conditions (e.g. sexual acting out, or suicide ideation) are present. In such cases, there is usually a great deal of overlap in the content of the Crisis and Safety Plan components.

Step 8: Tracking and Adapting

The CFT facilitator is responsible for creating an effective loop between the Behavioral Health Service Plan, its implementation, its effectiveness, and its modification when appropriate.

When and how should one facilitate Tracking and Adapting of the Behavioral Health Service Plan?

A significant failure of a CFT member to follow through on an important element of the Behavioral Health Service Plan will impede the momentum of the CFT, may threaten the commitment of other team members to the process, and may injure the child's/family's sense of hope. The CFT facilitator ensures that the CFT members carry out the Behavioral Health Service Plan.

The importance of *tracking assignment completion* is particularly essential early in the CFT process. The child's enrollment in the behavioral health system often occurs when needs are relatively high. As the CFT facilitator and team members develop closer relationships through engagement, interactions and collective accomplishments over time, CFT members will increase their understanding of each member's strengths and weaknesses, and realistic commitments and assignments will more naturally emerge in the continually evolving plan. Until then, the CFT facilitator invests time between team meetings to contact team members, offering gentle reminders and quick "Thank You's" to shape their follow-through behavior.

The CFT facilitator is also responsible for *tracking progress* on short-term objectives, and toward long-range goals. The Behavioral Health Service Plan includes short-term, observable and measurable objectives, and measurement indicators that will objectively reflect progress over time.

The CFT facilitator is responsible for *tracking effectiveness of Crisis and Safety Plans*. After a Crisis or Safety Plan is used, the CFT facilitator ensures that the CFT reviews its effectiveness.

The CFT facilitator works with the CFT to modify the Behavioral Health Service Plan when effectiveness or progress is not evident. Both lack of progress and follow-through on assignments by CFT members may indicate that certain options are not sufficiently individualized or customized to the

important cultural considerations of the child and family. Whatever the explanation is for a lack of progress, the CFT facilitator guides the team in refining existing strategies, or developing new options, thereby revising the Plan.

The CFT facilitator may delegate tracking functions to other willing members of the CFT, but when doing so should monitor to ensure that the designee is carrying out such tracking functions until reasonably assured that conscientious tracking will continue.

Step 9: Transition

ADHS universally applies the 12 Arizona Principles, and intends to use the CFT process with every child. The CFT does not "end" before the child is disenrolled from services or transitioned to the adult service system. The character of the team varies based on the goals, needs and strengths of each child and family, and each team functions in a unique and flexible manner, that may require varying levels of involvement from the behavioral health system, other child-serving agencies, and other natural supports. Some situations and some teams may, at least for a period of time, require designated CFT facilitators with specialized skills.

The final step of the CFT process is transition out of a formally supported process, sometimes from all formal services, and sometimes from child-oriented to more adult-oriented services as the child leaves adolescence for young adulthood (see *Transitioning to Adult Services Practice Improvement Protocol*). While many children and families are likely to experience some ongoing needs, they will often be able to capitalize on the identification and mobilization of informal supports and resources, and may continue to work with a support team that remains available to them after the CFT facilitator is no longer needed.

When and how should one facilitate the transition from a formally facilitated CFT process?

A further goal is to educate, support and empower families to eventually facilitate their own teams. Several guidelines help the CFT facilitator to know when to begin a gradual process of discontinuing formal facilitation of a CFT for the child and family. First, when sufficient informal support is available, transition is more likely to succeed. Team membership offers evidence of sufficient informal support. A CFT composed mostly of paid professionals does not indicate readiness for transition, and the CFT facilitator is reminded that team membership should be dynamic, working toward increasing participation of informal support persons over time. In some cases, the CFT facilitator may need to develop family advocates or mentors to support the team's necessary work. In general, CFTs composed of at least 50% informal support persons are best prepared for transition.

Youth and families who have assumed increasing responsibility for facilitation of their CFTs are approaching readiness for transition. The CFT facilitator should be consistently dedicated to the goal of helping the youth and family members to assume increasing responsibility for managing and facilitating their own CFT. Alternatively, another CFT member who is not a paid professional may be groomed by the CFT facilitator to assume that role. This requires that the CFT facilitator teaches the steps of the CFT process, models application of pertinent skills, provides constructive feedback and encouragement to team members intending to assume some, or all, facilitation responsibilities. Sometimes, youth and family members who have already become their own CFT facilitators may later be recruited to play a similar role with other families' teams.

When priority goals of the CFT have been achieved, as supported by tracked data, transition should be considered.

Finally, when a youth who has been involved in long term or intensive behavioral health care reaches the age of 16, planning for the transition into the adult behavioral health system must begin (refer to the T/RBHA specific version of the ADHS/DBHS Provider Manual Section 3.17, Transition of Persons for specific requirements). As the youth approaches his/her 18th birthday, and significant needs remain for formal support and services, the CFT facilitator works with the CFT to begin to invite one or more key contacts from adult service systems to join the dynamic team, laying the foundation for a smooth transition from the child-oriented service structure to the adult-oriented service structure. In such instances, the goal is to support continuity in the team process, including the provision of supports and services, plan components, and tracking and adapting processes.

The CFT facilitator begins to discuss the goal of transition from a formally supported CFT process with the child, family and CFT members relatively early in their relationships. As essentially a "secondary goal" of the CFT process from that early point, a clear expectation is set that guides the dynamic of the CFT process to change over time, gradually shifting reliance from formal to informal facilitative support.

Before any child is disenrolled, a crisis plan is developed that outlines the specific steps to be taken to reconvene the CFT, to re-establish services and supports should it become necessary.

Attachment 1: The Child and Family Team Process Encounters/Billing Codes Matrix

This table lists the nine essential steps of the Child and Family Team (CFT) process as described in ADHS clinical guidance documents. It identifies billing codes that can be used to reimburse qualified personnel carrying out those steps and their included activities. The table contains examples of codes that can be billed, but is *not* intended to be exhaustive. For more detailed information, please refer to the ADHS/DBHS Covered Behavioral Health Services Guide. Note that sometimes Child and Family Team (CFT) process activities do not actually occur in a linear (step by step) fashion, and also that there may be more than one appropriate choice for a billing code in some circumstances. Transportation, flex funds, and other covered services codes may also be furnished in support of the following steps and activities. Note: Providers may not bill separately for time spent documenting the activities and accomplishments of the CFT. Time associated with note-taking and/or medical record upkeep has been included in the rates for the billing codes listed.

Child & Family Team Process: Steps	Billing Codes Include:
1. Engagement of the Child and Family (and of extended family, informal and community supports, and representatives of from other involved child-serving entities)	**H0002**- Behavioral Health Screening **H0031**-Mental health assessment by non-physician **T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Professional (Out of Office) **T1016HN**-Case Management Behavioral Health Technician (Office) **T1016HN**- Case Management Behavioral Health Technician (Out of Office) **S5110**-Home Care Training Family (Family Support) **H0038** – Self-Help/Peer Services (Peer Support) **Behavioral Health Counseling and Therapy** codes as appropriate (see ADHS/DBHS Covered Behavioral Health Services Guide for particulars)
2. Immediate Crisis Stabilization	**H0002-** Behavioral Health Screening **H0031**-Mental Health Assessment by non-physician **T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Technician (Out of Office) **T1016HN**-Case Management Behavioral Health Technician (Office) **T1016HN**- Case Management Behavioral Health Professional (Out of Ofc) **S5110**-Home Care Training Family (Family Support) **H0038** – Self-Help/Peer Services (Peer Support) **S9986** - Non-Medically Necessary Covered Services (Flex Fund Services) **Behavioral Health Counseling and Therapy** codes as appropriate (see ADHS/DBHS Covered Behavioral Health Services Guide for particulars) Specific covered services to help stabilize crises, contingent on the specific needs of individual children and family members.

Child & Family Team Process: Steps	Billing Codes Include:
3. Strengths, Needs and Culture Discovery	**H0031**- Mental Health Assessment by non-physician **T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Professional (Out of Office) **T1016HN**-Case Management by Behavioral Health Technician (Office) **T1016HN**- Case Management by Behavioral Health Technician (Out of Office) **H0004HR-** Family Behavioral Health Counseling (Office – client present) **H0004HR**- Family Behavioral Health Counseling (Out of Office – client present) **H0004HS**- Family Behavioral Health Counseling (Office - without client) **H0004HS**- Family Behavioral Health Counseling (Out of Office - without client)
4. Child and Family Team Formation	**S5110**- Home Care Training Family (Fam. Supp.) **H0038** – Self-Help/Peer Services (Peer Support) **T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**- Case Management Behavioral Health Professional (Out of Office) **T1016HN**-Case Management Behavioral Health Technician (Office) **T1016HN-**Case Management Behavioral Health Technician (Out of Office) **H0004HR-** Family Behavioral Health Counseling (Office – client present) **H0004HR**- Family Behavioral Health Counseling (Out of Office – client present) **H0004HS**- Family Behavioral Health Counseling (Office - without client) **H0004HS**- Family Behavioral Health Counseling (Out of Office - without client) **H2016-**Comprehensive **C**ommunity Support (Peer Support)
5. Behavioral Health Service Plan – Development	**T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Professional (Out of Office) **T1016HN**-Case Management Behavioral Health Technician (Office) **T1016HN**- Case Management Behavioral Health Technician (Out of Office) **H0004HR-** Family Behavioral Health Counseling (Office – client present) **H0004HR**- Family Behavioral Health Counseling (Out of Office – client present)

Child & Family Team Process: Steps	Billing Codes Include:
	H0004HS- Family Behavioral Health Counseling (Office - without client) **H0004HS**- Family Behavioral Health Counseling (Out of Office - without client) **S5110-** Home Care Training Family (Family Support) **H0038** – Self-Help/Peer Services (Peer Support) *Providers may not bill separately for time spent documenting the activities and accomplishments of the CFT. Time associated with note-taking and/or medical record upkeep has been included in the rates for the billing codes listed.
6. Behavioral Health Service Plan – Implementation	**T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Professional (Out of Office) **T1016HN**-Case Management Behavioral Health Technician (Office) **T1016HN** – Case Management Behavioral Health Technician (Out of Office) All covered services identified as needed by the Child and Family Team (CFT)
7. Ongoing Crisis and Safety Planning	**T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Professional (Out of Office) **T1016HN**-Case Management Behavioral Health Technician (Office) **T1016HN**- Case Management Behavioral Health Technician (Out of Office) **H0004HR-** Family Behavioral Health Counseling (Office – client present) **H0004HR**- Family Behavioral Health Counseling (Out of Office – client present) **H0004HS**- Family Behavioral Health Counseling (Office - without client) **H0004HS**- Family Behavioral Health Counseling (Out of Office - without client) **S5110-** Home Care Training Family (Family Support) **H0038** – Self-Help/Peer Services (Peer Support) **H2014** – Skills Training and Development - Individual **S9986** - Non-Medically Necessary Covered Services (Flex Fund Services)
8. Tracking and Adapting	**T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Professional (Out of Office)

Child & Family Team Process: Steps	Billing Codes Include:
	T1016HN-Case Management Behavioral Health Technician (Office) **T1016HN**- Case Management Behavioral Health Technician (Out of Office) **H0004HR-** Family Behavioral Health Counseling (Office – client present) **H0004HR**- Family Behavioral Health Counseling (Out of Office – client present) **H0004HS**- Family Behavioral Health Counseling (Office - without client) **H0004HS**- Family Behavioral Health Counseling (Out of Office - without client) **S5110-** Home Care Training Family (Family Support) **H0038** – Self-Help/Peer Services (Peer Support) * Providers may not bill separately for time spent documenting the activities and accomplishments of the CFT. Time associated with note-taking and/or medical record upkeep has been included in the rates for the billing codes listed.
9. Transition	**T1016H0**-Case Management Behavioral Health Professional (Office) **T1016H0**-Case Management Behavioral Health Professional (Out of Office) **T1016HN**-Case Management Behavioral Health Technician (Office) **T1016HN**- Case Management Behavioral Health Technician (Out of Office) **H0004HR-** Family Behavioral Health Counseling (Office – client present) **H0004HR**- Family Behavioral Health Counseling (Out of Office – client present) **H0004HS**- Family Behavioral Health Counseling (Office - without client) **H0004HS**- Family Behavioral Health Counseling (Out of Office - without client) **S5110-** Home Care Training Family (Family Support) **H0038** – Self-Help/Peer Services (Peer Support)